PODIATRY SERVICES

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A. DEFINITION

"Podiatry services" are those services provided by individuals licensed under state law to practice podiatry which are within the scope of the practices of the profession.

B. BENEFITS AND LIMITATIONS

1. ICD-9-CM Diagnosis Codes are mandatory when completing claims for the Montana Medicaid Program.

2. Podiatry services may be provided in:

   - The Podiatrist's Office
   - The Recipient's Home
   - The Hospital
   - Intermediate Care Facilities
   - Skilled Nursing Facilities
   - Extended Care Facilities

3. Utilization and peer review of podiatry services shall be conducted by the designated review organization.

4. Medicaid payments are not available for podiatry services unless the services are considered medically necessary. Procedures considered experimental are not a benefit of Medicaid.

C. DIAGNOSIS AND PROCEDURE CODES

The HCFA-1500 claim form is used to submit podiatry services to Medicaid. ICD-9-CM diagnosis codes must be used on the claim forms to indicate diagnosis, and CPT-4 procedure codes must be used on the claim forms to reflect the specific procedures or services provided. The following list of codes are HCPCS Level II and Level III codes and are to be used **only** when an appropriate CPT-4 (HCPCS Level I) code does not exist.

ROUTINE PODIATRIC PROCEDURES

M0101 Cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care. (Excludes debridement of nails.)

PODIATRIC ORTHOMECHANICAL SERVICES AND PROCEDURES

The following procedure codes and ranges of codes are available for use if no CPT-4 (HCPCS Level I) code is suitable:

L1900 - L1999	L3265
L3000 - L3199	L3300 - L3599
L3204 - L3214	L3600 - L3620
L3218, L3223, L3260	L5000 - L5020

Ankle-Foot Orthoses (For bilateral procedures use modifier 50)

Z0252 Foot imprints and/or outlines. Independent procedure for prescribing of plantar footpads or plates for evaluating surface contact areas of feet.

Z0253 Foot, ankle and leg measurements, including foot imprints and outlines of feet for prescribing of orthotics, prosthetics or custom, hand-made shoes for orthopedic foot deformities.

Z0256 Ankle brace without modification, with or without stays (stock item), single.

Metal Foot Plates

Z0257 Shaeffer plate or any other custom made metal plate (custom made to model), single.

Z0259 Mobilization of toe or toe-joint by use of an orthodigital traction device (toe aligning sling) made to plaster model for the correction of hallux valgus, hammer toe, underlapping or overlapping toes, etc., single.

Thermoplastic Plates (Biochemical)

Z0261 Stabilization and/or mobilization of foot by use of a thermoplastic orthotic (custom made to model and biomechanically), with forefoot post, single.

Z0263 Addition of rearfoot post, single.

Z0265 Addition of forefoot post, single.

Z0267 Stabilization of heel by use of heel stabilizer, made to plaster model, single.

Z0269 Heel stabilizer (plastic heel cup), stock item, single.

Shoes Modifications, Exterior

Z0271 Stabilization and/or mobilization of foot by use of exterior modifications to shoes such as orthopedic heels, comma bars, heel or sole wedges, etc., pair; or buildup for shortage, per shoe.

Molded Inlay (Balance Inlays)

Z0273 The stabilization, balance and mobilization of the foot, partial or total by use of a full extension or partial molded inlay made to foot models with an elevation up to 3/4" and with a matching insert as an interior shoe modification. Removable type (all types of balance inlays, Bergmann, Levy, Grachman, Contur-A-Mold, Molded Latex, etc.), single with matching insert or a pair.

Shoe Modifications, Interior (Shoe paddings, etc.)

Z0274 The stabilization and removal of pressure from the affected areas of the feet by use and application of accommodative shoe paddings to the interior of the shoe, pair.

Z0275 Stabilization, equilibrium and restoration of balance to the feet and legs by use of an interior modification for the shoe by means of a removable insert formed as a prosthetic for amputation of toe, toes, or forefoot. Single with matching insert to balance the normal foot.

Splints (See CPT-4 codes 29505 through 29799)

Cast Impressions and Models

Z0279 Plaster foot cast, negative impression, of a toe or part of the foot, as an independent procedure for prescribing of an orthotic or prosthetic, single.

AUTOMATED, MULTICHANNEL TESTS

The following list contains those tests that can be and are frequently done as groups and combinations ("profiles") on automated multichannel equipment. For reporting two tests, regardless of method of testing, use appropriate single test code numbers as listed in the CPT-4 manual.

For any combination of three or more tests among those listed immediately below, use the appropriate CPT-4 code in the range 80002 to 80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate "stat" reporting.

Albumin
Albumin/globulin ratio
Bilirubin, direct
Bilirubin, total
Calcium
Carbon dioxide content
Chlorides
Cholesterol
Creatinine
Globulin
Glucose (sugar)
Lactic dehydrogenase (LDH)
Phosphatase, alkaline
Phosphorus (inorganic phosphate)
Potassium
Protein, total
Sodium
Transaminase, glutamic oxaloacetic (SGOT)
Transaminase, glutamic pyruvic (SGPT)
Urea nitrogen (BUN)
Uric acid

SUPPLIES FOR IN OFFICE SURGICAL PROCEDURES

Procedure 99070, office supplies, has been used to bill supply items not customarily included as part of the service. Medicaid is implementing surgical supply codes to be used in place of code 99070. Please refer to Appendix B at the back of this handbook section for the surgical supply codes billable to Medicaid.

Code 99070 should continue to be used when billing for non surgical supplies and materials that are not customarily included as part of the service. Medicaid has set a maximum allowed fee for code 99070 of $45.00

MEDICAID DOES NOT PROVIDE ADDITIONAL REIMBURSEMENT FOR THE "OPERATING ROOM" IN A PROVIDER'S OFFICE. Medicaid reimburses licensed facility sites for "outpatient" and inpatient surgical services. The facility bills for their portion of the surgical service including the supplies.

D. REIMBURSEMENT

Medicaid payment for podiatry services shall be the lowest of the provider's actual (submitted) charge for the services, the maximum allowed by Medicare (for services covered by Medicare), or the Medicaid fee schedule. The Medicaid fee for services paid By Report (B.R.) is 70% of billed charges.

E. LABORATORY

A podiatrist billing for laboratory services performed by him or under his direct supervision in his office, and independent laboratories billing for laboratory services, shall be paid the lowest of the provider's actual (billed) charge for the service; the Medicaid fee schedule; or 60% of the Medicare prevailing.

A podiatrist may not bill and be paid for laboratory work done outside of his office. Independent laboratories are required to bill Medicaid directly for their services. The handling and collection fee is $3.00 per recipient per date of service, regardless of the number or types of specimens collected from the patient.

F. REMITTANCE ADVICE (RA)

When a payment or denial has been made on your submitted claims, you will receive a REMITTANCE ADVICE (RA). The RA is sent weekly as your claims are processed.

- The RA explains the payment, reasons for denials or non-payment.

- For claims which have been denied, you must fix the problem as explained by the denial reason and resubmit the claim to be processed by Consultec.

  NOTE: Consultec is not authorized to correct or change information on your claims, such as wrong ID numbers, wrong provider numbers, missing diagnosis codes, etc.

- If you don't understand the explanation of the problem on the RA, please call Provider Relations at Consultec, 1-800-624-3958 or 442-1837 for assistance.

- The RA is your proof that the claim has been received and processed by Consultec. The RA's are to be retained in your office for future reference or audit.

G. CLAIMS RESOLUTION/PROCESSING

You must provide all the required information in each field for your claim to be considered a "clean" claim and processed for payment. Reasons for denials or suspensions by Medicaid are explained on your RA.

> **Example:** The wrong ID number was entered on the HCFA-1500. You must correct the recipient ID number and resubmit the corrected claim to Consultec for processing. Photocopies can be used for resubmission as long as they are signed and legible.

When you identify that the information from your claim was not processed correctly, please contact Consultec with the ICN number of the claim (the ICN number is shown on the RA) and notify the provider relations department of the error. The Consultec staff will take the necessary steps to correct any claim processing or keying errors.

H. CLAIM ADJUSTMENTS - WHEN TO USE THIS FORM

You will use the Adjustment Request Form when you are correcting an error on a claim which **has been paid**. Please refer to Section VIII of the Medicaid Provider Handbook for detailed instructions on the use of the Adjustment Request Form.

> **Example:** The wrong procedure code was billed, keyed and paid. As a result, the payment amount is wrong. You would complete an adjustment form to have the code on the paid claim corrected. Attach a copy of the claim and the RA and submit the Adjustment Request to Consultec.

If you don't know what steps need to be taken to resolve a problem, please write or call:

Provider Relations/Consultec
P.O. Box 8000
Helena, MT 59601
1-800-624-3958, In-State Toll Free Line
or (406) 442-1837, Helena and Out of State

The Provider Relations staff are trained to assist you with adjustments, resubmittals and claims processing questions.

When the problem is clearly related to Medicaid policy and procedure issues, the Consultec staff will refer you to the Primary Care Section of the Medicaid Bureau for additional information or review. Medicaid policy or reimbursement questions can be addressed directly to:

Medicaid Services Division
Department of SRS
P.O. Box 4210
Helena, MT 59604 (406) 444-4540

I. MOST COMMON CLAIMS PROBLEMS

Claims are often submitted to Medicaid with wrong Medicaid ID numbers. These errors have been known to result in denials when the wrongly identified patient is not eligible.

The solution to these and related problems is to be overly cautious with recipient identification numbers and to investigate and correct claims with these denial explanations.

Another common problem with claims is that they are often filed prior to being submitted to Medicare or other insurance carriers for payment. With the lone exception of Indian Health, Medicaid is the payor of last resort. When another payor is involved, claims cannot be processed by Medicaid without being accompanied by either a denial or statement indicating the payment from the relevant third party payor.

If you have billed the other insurance and have waited 90 days with no response from them, you may bill Medicaid as follows:

> Attach a note to the HCFA-1500 explaining that you have attempted to bill the other insurance and the date you submitted the claim to them. Send this information to:
>
> Consultec, Inc.
> Third Party Liability Department
> P.O. Box **5838**
> Helena, MT 59604

Claims are frequently denied for not being submitted within the timely filing requirements. The rule states that 'providers shall submit "clean" claims within twelve (12) months of:

- the date the service was performed,
- the date the applicant's eligibility was determined, or
- the date disability was determined.'

A "clean claim" is one which can be processed for payment without additional information, documentation or correction from the provider of the service. **IT IS THE PROVIDER'S RESPONSIBILITY TO FOLLOW UP ON CLAIMS AND INSURE THAT THEY ARE RECEIVED WITHIN THE TWELVE MONTH LIMIT.** The date of submission to the Medicaid program is the date the claim is stamped received by the fiscal agent or the Department. **A claim lost in the mail is not considered received.**

The best method to guard against claim denial for this reason is to establish and employ strict office procedures for identifying and following up on patient payment sources. If you have repeatedly billed a patient and suspect them to be Medicaid, ask them to mail you a copy of their Medicaid card. You should also make a habit of checking with other providers to see how they obtained payment.

A final problem area involves duplicate medical services or more than one surgical procedure being billed for the same date of service. These are usually the more complicated medical cases. If you feel this may cause a problem with Medicaid payment, then a letter of explanation or appropriate medical records should be attached to your claim. This additional information can be used to facilitate the evaluation of multiple surgical procedures performed on the same day.

J. ICD-9-CM DIAGNOSIS CODES

Diagnosis codes are required on Medicaid claims. Please assist other providers, such as pathologists and anesthesiologists, by making patient's diagnosis codes available to the respective billing offices.

K. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code, which is a two digit alpha or numeric indicator placed **after** the usual procedure number from which it is separated by a hyphen. Definitions of modifiers accepted by the Montana Medicaid Program are contained in Appendix A of this manual.

L. MODIFIER REIMBURSEMENT

Medicaid reimbursement for podiatry services is always the lower of:

1. the Medicaid fee,
2. the Medicare fee, or
3. the provider's billed charge.

MODIFIERS PRICED AT PERCENT OF FEE

Effective July 1, 1991, the Medicaid fee for certain modified services is based on a percentage of the established fee (for procedures with a set Medicaid fee). The modifiers and related percentages are listed below.

PROCEDURE MODIFIER	PERCENT OF MEDICAID FEE	PROCEDURE MODIFIER	PERCENT OF MEDICAID FEE
26	40 %	TC	60 %
32	100 %	50	100 %
51	100 %	52	100 %
54	100 %	55	100 %
56	100 %	62	100 %

76	100 %	77	100 %
80	50 %	81	50 %
82	50 %	90	100 %
99	100 %	AN, AU, XC	80 %
AS	50 %		

For procedures without a set fee (by-report procedures), the Medicaid fee is based on 70% of the billed charge.

MODIFIERS PRICED BY-REPORT

Procedures billed with the following Modifiers have a Medicaid fee of 70% of billed charges (whether the base procedure has an established fee or not).

20, 22, 47, & 66

M. MEDICARE MODIFIERS

Medicaid recognizes certain Medicare modifiers as informational only. This facilitates the processing of Medicare/Medicaid "Crossover" claims.

Medicare modifiers accepted by Medicaid for informational purposes are: AH, AJ, AK, AM, AP, AT, CC, DD, EJ, EM, ET, FP, LR, LS, LT, MP, MS, NR, NU, PL, QB, QC, QD, QU, RR, RT, SF, SP, VE, VP, YY, ZZ, WA, WU, XM, XQ, XR, XS, YC, YL, YU, YX.

APPENDIX A - DEFINITIONS

I TERMS AND PHRASES COMMON TO THE PRACTICE OF MEDICINE

NEW AND ESTABLISHED PATIENT: A new patient is one who has not received any professional services from the physician within the past three years.

An established patient is one who has received professional services from the physician within the past three years.

In the instance where a physician is on call (or covering) for another physician, the patient's service should be classified as it would have been by the physician who is unavailable.

There is no distinction between new and established patients in the emergency department. E/M services in the emergency department category are to be reported for any patient (new or established) who presents for treatment in that location.

CONCURRENT CARE: is the provision of similar services, eg, hospital visits, to the same patient on the same day by more than one physician. No special reporting is required when concurrent care is provided. Modifier -75 has been deleted.

COUNSELING: is a discussion with a patient and/or family about one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) and/or follow-up;
- importance of compliance with chosen management (treatment) options;
- risk factor reduction; and
- patient and family education.

LEVELS OF SERVICE: The levels of E/M services include examinations, evaluations, treatments, conferences with or about patients, preventive pediatric and adult health supervision, and similar medical services. The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians.

The descriptions for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- history;
- examination;

- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (history, examination and medical decision making) are considered the **key** components in selecting a level of E/M services.

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in detail following (see below).

Diagnostic tests or studies for which specific CPT codes are available are **not** included in the levels of E/M services. Physician performance of diagnostic tests and studies for which specific CPT codes are available should be reported separately, *in addition* to the appropriate E/M code.

NATURE OF PRESENTING PROBLEM: A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal - A problem that may not require the presence of the physician, but service is provided under the physician's supervision.
- Self-limited or Minor - A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
- Low severity - A problem where the risk of morbidity without treatment is low; there is little or no risk of mortality without treatment; full recovery without functional impairment is expected.
- Moderate severity - A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- High severity - A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

TIME: The inclusion of time as an explicit factor beginning with 1992 CPT is done to assist physicians in selecting the most appropriate level of E/M code. **The specific times shown in the visit code descriptions are averages. They represent a range of times which may be higher or lower depending on actual clinical circumstances.**

Time is **not** a descriptive component for the emergency room levels of E/M codes because emergency room services are multiple encounters with several patients over an extended period of time. For this reason it is often difficult for physicians to provide accurate estimates of the time spent fact-to-face with the patient.

Intra-service times are defined as **face-to-face** time for office and other outpatient visits. It is also defined as **unit/floor** time for hospital and other inpatient visits. Most of the work typical of office visits takes place during the face-to-face time with the patient. Most of the work typical of hospital visits takes place during the time spent on the patient's floor or unit.

a. Face-to-face time (office and other outpatient visits and office consultations): For coding purposes, face-to-face time for these services is only time that the physician spends face-to-face with the patient and/or family. This includes time in which the physician performs such tasks as obtaining history, performing an examination, and counseling the patient.

b. Unit/floor time (inpatient hospital care, initial and follow-up hospital consultations, nursing facility): For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the physician is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.

SPECIAL REPORT: an unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort and equipment necessary to provide the service. Additional items which may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

UNLISTED PROCEDURE OR SERVICE: It is recognized there may be services or procedures performed by physicians that are not found in the HCPCS coding system. Therefore, a number of specific code numbers are designated for reporting unlisted procedures. However, the unlisted procedure number is **not to be used for a procedure already listed.**

MATERIALS SUPPLIED BY PHYSICIANS: In general there is no separate reimbursement for supplies and materials included with the office visit or other services. Supplies and materials provided by the physician over and above those usually included with in-office surgery may be billed with the specific codes listed in Appendix B. Code 99070 may be used for items not included in that listing.
Medicaid has established a maximum payment limit for 99070. Post payment reviews may be conducted to determine appropriate billing for supplies.

II EVALUATION AND MANAGEMENT SERVICE GUIDELINES

Select the appropriate level of E/M services based on the following:

1. For the following categories/subcategories, **ALL OF THE KEY COMPONENTS** (i.e. history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service:

    - office, new patient;
    - initial hospital care;
    - office consultations;
    - initial inpatient consultations;
    - confirmatory consultations;
    - emergency department services;
    - comprehensive nursing facility assessments;
    - domiciliary care, new patient; and
    - home, new patient.

2. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (i.e. history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services:
    - office, established patient;
    - subsequent hospital care;
    - follow-up inpatient consultations;
    - subsequent nursing facility care;
    - domiciliary care, established patient; and
    - home, established patient.

3. In the case where counseling and/or coordination of care dominates the face-to-face physician/patient encounter (more than 50%), then **time** is considered the key or controlling factor to qualify for a particular level of E/M services. The extent of counseling and/or coordination of care must be documented in the medical record.

MODIFIERS FOR USE WITH E/M CODES: Listed services may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code. The modifier is reported by a two digit number placed after the usual procedure number from which it is separated by a hyphen. The modifiers which are valid for use with E/M codes are:

21, 24, 25, 32, 52, 78, and 79

These modifiers are defined in the following pages.

III MODIFIERS

CPT-IV MODIFIERS COMMONLY USED IN **MEDICINE**

- 21 Prolonged Evaluation and Management Services: When the service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding the modifier '-21' to the evaluation and management code number. A report may also be appropriate.

- 22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number. Medical records or reports may be requested by Medicaid.

- 23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier '-23' to the procedure code of the basic service.

- 24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier '-24' to the appropriate level of E/M service.

- 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier '-25' to the usual procedure number.

- 26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When reporting the physician component separately use modifier '-26'. (eg, laboratory, radiology, electrocardiograms, etc.) Medical records or reports may be requested by Medicaid.

- TC Technical component: When reporting the technical component to a procedure use modifier '-TC'. Medical records or reports may be requested by Medicaid.

- 32 Mandated Services: Services related to mandated consultation and/or related services (eg, PRO, 3rd party payor) may be identified by adding modifier '-32' to the basic procedure.

- 51 Multiple Procedures: When multiple, but separate procedures are performed on the same day or at the same session, the major procedure or service may be reported as listed. The secondary, additional, or lesser procedure(s) or service(s) may be identified by adding the modifier '-51' to the secondary procedure or service code(s). This modifier may be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical

procedures, or several surgical procedures performed at the same operative session. Medical reports or records may be requested by Medicaid.

- 52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '- 52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

- 55 Postoperative Management Only: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier '-55'.

- 56 Preoperative Management Only: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier '- 56' to the usual procedure number.

- 76 Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding modifier '-76' to the repeated service. Medical records or reports may be requested by Medicaid.

- 77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding '-77' to the repeated service. Medical records or reports may be requested by Medicaid.

- 79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier '-79'. (For repeat procedures on the same day, see -76.)

- 99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier '-99' should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service. Medical records or reports may be requested by Medicaid.

- AN Physician assistant services for other than assistant-at-surgery. This modifier is to be used only for physician assistants, and not for services provided by registered nurses or nurse specialists (i.e. nurse practitioners, nurse midwives or nurse anesthetists).

- AU Same as '-AN'.

CPT-IV MODIFIERS COMMONLY USED IN **SURGERY**

In addition to the listing of modifiers under Medicine, the following modifiers may be used with surgical services.

- 20 Microsurgery: When the surgical services are performed using the techniques of microsurgery, requiring the use of an operating microscope, modifier '-20' may be added to the surgical procedure. Modifier '-20' is not to be used when a magnifying surgical loupe is used, whether attached to the eyeglasses or on a headband. A special report may be requested to document the necessity of the microsurgical approach.

- 47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding modifier '-47' to the basic service. (This does not include local anesthesia.) Note Modifier '-47' would not be used as a modifier for anesthesia procedures 00100-01999.

- 50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by the appropriate five digit code describing the procedure followed by modifier '-50'.

- 54 Surgical Care only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier '-54' to the usual procedure number.

- 62 Two Surgeons: Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances the separate service may be identified by adding the modifier '-62' to the procedure number used by each surgeon for reporting his services. Medical records or reports may be requested by Medicaid.

- 66 Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical teams" concept. Such circumstances may be identified by each participating physician with the addition of modifier '-66' to the basic procedure number used for reporting services. Medical records or reports may be requested by Medicaid.

- 78 Return to the Operating Room for a Related Procedure During the Postoperative Period: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier '-78' to the related procedure.

- 80 Assistant Surgeon: Surgical assistant services may be identified by adding the modifier '-80' to the usual procedure code. Medical records or reports may be requested by Medicaid. Medicaid does not reimburse for a nurse assisting at surgery.

- 81 Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding the modifier '-81' to the usual procedure code number. This modifier is not to be used if the service is provided by a nurse assistant at surgery. Medicaid does not reimburse for a nurse assisting at surgery.

- 82 Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier '-82'. This modifier is not to be used if the service is provided by a nurse assistant at surgery. Medicaid does not reimburse for a nurse assisting at surgery.

- AS Physician Assistant services: use this modifier when the Physician Assistant is the assistant at surgery. Do not use this modifier if the assistant at surgery is a nurse.

CPT-IV MODIFIERS VALID FOR **RADIOLOGY** AND **LABORATORY** SERVICES

The following modifiers are valid for Radiology and Laboratory services:

Radiology: 22, 26, TC, 32, 51, 52, 62, 66, 75, 76, 77, 80, 90, 99
Laboratory: 22, 26, TC, 33, 52, 90

APPENDIX B - SURGICAL SUPPLY CODES

CODE	DESCRIPTION	FEE *
A4200	Gauze pads, sterile or non sterile	65.2%
A4201	Gelfoam, per bottle	65.2%
A4202	Elastic bandages, sterile or non-sterile	65.2%
A4206	Syringe with needle, sterile 1 cc	.24
A4207	Syringe with needle, sterile 2 cc	.24
A4208	Syringe with needle, sterile 3 cc	.24
A4209	Syringe with needle, sterile 5 cc or greater	.24
A4213	Syringe, sterile, 20 cc or greater	65.2%
A4214	Sterile saline or water, 30 cc vial	65.2%
A4215	Needles only, sterile, any size	65.2%
A4216	Hemostatic cellulose (e.g.surgical) any size	65.2%
A4245	Alcohol wipes, per box	65.2%
A4247	Betadine or iodine swabs/wipes,per box	65.2%
A4252	Irrigation kits, nonsterile	65.2%
A4450	Adhesive tape, all sizes	65.2%
A4453	Microporous tapes, all sizes	65.2%
A4460	Elastic bandage, ace	65.2%
A4550	Surgical trays (includes surgical gloves)	65.2%
A4555	Primary surgical dressing kit, sterile dressings	65.2%
A4560	Pessary	65.2%
A4565	Slings	65.2%
A4570	Splint	65.2%
A4580	Cast supplies	65.2%
A4590	Special casting materials, hexcelite/light cast	65.2%

*** the 65.2% fee is a percentage of the providers billed charge for the code.**